

## **ACE Inhibitors, Angiotensin II Receptor Antagonists, Beta-Blockers**

**LENGTH OF AUTHORIZATIONS:** 1 year

Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class? Acceptable reasons include:

Allergy to medications not requiring prior approval

Contraindication to or drug-to-drug interaction with medications not requiring prior approval

History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

The requested medication may be approved if both of the following are true:

If there has been a therapeutic failure to no less than a **one-month trial** of at least **one** medication **within the same class** not requiring prior approval

The requested medications corresponding generic (if a generic is available and covered by the State) has been attempted and failed or is contraindicated

### **ADDITIONAL INFORMATION TO AID IN FINAL DECISION**

If there is a specific indication for a medication requiring prior approval, for which medications not requiring prior approval are not indicated, then may approve the requested medication. Document details. This medication should be reviewed for need at each request for reauthorization.

See next page for specific drug lists.

## ACE Inhibitors, Angiotensin II Receptor Antagonists, Beta-Blockers *(page 2)*

### ACE INHIBITORS and HCTZ COMBINATIONS

NO PA REQUIRED "PREFERRED"	PA REQUIRED <i>(medications in italics have a preferred generic available)</i>
CAPTOPRIL (compares to Capoten®) CAPTOPRIL/ HCTZ (compares to Capozide®) ENALAPRIL (compares to Vasotec®) ENALAPRIL/ HCTZ (compares to Vaseretic®) LISINOPRIL (compares to Zestril®, Prinivil®) LISINOPRIL/HCTZ (compares to Zestoretic®, Prinzide®)	ACCUPRIL® ACCURETIC® ACEON® ALTACE® BENAZEPRIL CAPOTEN® CAPOZIDE® FOSINOPRIL FOSINOPRIL HCTZ LOTENSIN® LOTENSIN HCT® MAVIK® MOEXIPRIL MONOPRIL® MONOPRIL HCT® PRINIVIL® PRINIZIDE® QUINAPRIL QUINAPRIL/HCTZ UNIRETIC® UNIVASC® VASERETIC® VASOTEC® ZESTORETIC® ZESTRIL®

### ACE INHIBITOR PLUS CALCIUM CHANNEL BLOCKER COMBINATIONS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
LOTREL® (Norvasc® and Lotensin®)	LEXXEL® (Plendil® and Enalapril) TARKA® (Verapamil and Trandolapril) TECZEM® (Diltiazem and Enalapril)

### ANGIOTENSION II RECEPTOR ANTAGONISTS and HCTZ COMBINATIONS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
BENICAR® BENICAR HCT® COZAAR® DIOVAN® DIOVAN HCT® HYZAAR® MICARDIS® MICARDIS HCT®	ATACAND® ATACAND HCT® AVALIDE® AVAPRO® TEVETEN® TEVETEN HCT®

## ACE Inhibitors, Angiotensin II Receptor Antagonists, Beta-Blockers *(page 3)*

### BETA-BLOCKERS

NO PA REQUIRED "PREFERRED"	PA REQUIRED <i>(medications in italics have a preferred generic available)</i>
ACEBUTOLOL (compares to Sectral <sup>®</sup> ) ATENOLOL (compares to Tenormin <sup>®</sup> ) ATENOLOL /CHLORTHALIDONE (compares to Tenoretic <sup>®</sup> ) BETAXOLOL (compares to Kerlone <sup>®</sup> ) BISOPROLOL FUMARATE (compares to Zebeta <sup>®</sup> ) BISOPROLOL/HCTZ (compares to Ziac <sup>®</sup> ) COREG <sup>®</sup> LABETALOL (compares to Trandate <sup>®</sup> ) METOPROLOL TARTRATE (compares to Lopressor <sup>®</sup> ) NADOLOL (compares to Corgard <sup>®</sup> ) PINDOLOL (compares to Viskin <sup>®</sup> ) PROPRANOLOL (compares to Inderal <sup>®</sup> ) PROPRANOLOL/HCTZ (compares to Inderide <sup>®</sup> ) SORINE (compares to Betapace <sup>®</sup> ) SORINE AF (compares to Betapace AF <sup>®</sup> ) SOTALOL (compares to Betapace <sup>®</sup> ) SOTALOL AF (compares to Betapace AF <sup>®</sup> ) TIMOLOL (compares to Blocadren <sup>®</sup> )	<i>BETAPACE<sup>®</sup></i> <i>BETAPACE AF<sup>®</sup></i> <i>BLOCADREN<sup>®</sup></i> CARTROL <sup>®</sup> <i>CORGARD<sup>®</sup></i> CORZIDE <sup>®</sup> (Nadolol/Bendroflumethiazide) DEMSER <sup>®</sup> <i>INDERAL<sup>®</sup></i> INDERAL LA <i>INDERIDE<sup>®</sup></i> INNOPRAN XL <sup>®</sup> <i>KERLONE<sup>®</sup></i> LEVATOL <sup>®</sup> <i>LOPRESSOR<sup>®</sup></i> LOPRESSOR HCT <sup>®</sup> <i>SECTRAL<sup>®</sup></i> <i>TENORETIC<sup>®</sup></i> <i>TENORMIN<sup>®</sup></i> TIMOLIDE <sup>®</sup> TOPROL XL <sup>®</sup> <i>TRANDATE<sup>®</sup></i> <i>ZEBETA<sup>®</sup></i> <i>ZIAC<sup>®</sup></i>

#### TOPROL XL<sup>®</sup>: Authorize if any of the following are true

- Toprol XL<sup>®</sup> 25mg po qd will be authorized as it would not be feasible to promote metoprolol 12.5mg po BID. Toprol XL<sup>®</sup> 25mg will be authorized with a quantity limit of 45 tablets per 30 days.
- Doses >37.5 mg Toprol XL<sup>®</sup> po qd will be offered a change to metoprolol in a total daily dose divided by two and dosed BID
- If patient compliance is questioned or compromised by change, then the Toprol XL<sup>®</sup> will be authorized

## Antibiotics: Cephalosporins, Macrolides, Quinolones

**LENGTH OF AUTHORIZATIONS:** for the date of service only; no refills

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?  
Acceptable reasons include:  
Allergy to product formulation (i.e. dyes, fillers). If allergy to drug class, should question medication request.  
Contraindication to or drug-to-drug interaction with medications not requiring prior approval  
History of unacceptable/toxic side effects to medications not requiring prior approval  
Document clinically compelling information
2. If the infection is caused by an organism resistant to medications not requiring prior approval, then may approve the requested medication. Document details.
  - Note diagnosis and any culture and sensitivity reports
3. If there has been a therapeutic failure to no less than a **three-day** trial of **one** medication within the same not requiring prior approval, then may approve the requested medication. Document details.

### **ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION**

If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital, then may approve the requested medication to complete the course of therapy.

If the patient requires a prior authorized medication based on a specific medical need that is not covered by the FDA indications of the preferred medications, then allow the non-preferred medication. This information should be reviewed at each request for reauthorization.

### **CEPHALOSPORINS - SECOND GENERATION**

<b>NO PA REQUIRED "PREFERRED"</b>	<b>PA REQUIRED</b> <i>(medications in italics have a preferred generic available)</i>
CEFACLOR CEFACLOR Suspension CEFACLOR ER CEFTIN 125 mg (until generic available) CEFTIN <sup>®</sup> Suspension CEFUROXIME (compares to Ceftin <sup>®</sup> ) CEFZIL <sup>®</sup> CEFZIL <sup>®</sup> Suspension LORABID <sup>®</sup> LORABID <sup>®</sup> Suspension	<i>CECLOR<sup>®</sup>*</i> <i>CECLOR CD<sup>®</sup>*</i> <i>CEFTIN<sup>®</sup>*</i>

### **CEPHALOSPORINS - THIRD GENERATION**

<b>NO PA REQUIRED "PREFERRED"</b>	<b>PA REQUIRED</b>
CEDAX <sup>®</sup> CEDAX <sup>®</sup> Suspension OMNICEF <sup>®</sup> OMNICEF <sup>®</sup> Suspension SPECTRACEF <sup>®</sup>	Cefpodoxime SUPRAX <sup>®</sup> Suspension VANTIN <sup>®</sup> VANTIN <sup>®</sup> Suspension

## Antibiotics – Cephalosporins, Macrolides, Quinolones *(page 2)*

### MACROLIDES

NO PA REQUIRED “PREFERRED”	PA REQUIRED <i>(medications in italics have a preferred generic available)</i>
BIAXIN <sup>®</sup> BIAXIN <sup>®</sup> Suspension BIAXIN XL <sup>®</sup> ERYTHROCIN STEARATE ERYTHROMYCIN BASE ERYTHROMYCIN ETHYLSUCCINATE ERYTHROMYCIN ESTOLATE Suspension ERYTHROMYCIN STEARATE ERYTHROMYCIN W/SULFISOXAZOLE ZITHROMAX <sup>®</sup> ZITHROMAX <sup>®</sup> Suspension	DYNABAC <sup>®</sup> <i>E.E.S.</i> <sup>®</sup> <i>ERYC</i> <sup>®</sup> <i>ERYPED</i> <sup>®</sup> <i>Ery-Tab</i> <sup>®</sup> <i>PCE</i> <sup>®</sup>

### QUINOLONES - SECOND GENERATION

NO PA REQUIRED “PREFERRED”	PA REQUIRED
CIPROFLOXACIN (generic for Cipro <sup>®</sup> ) OFLOXACIN	CIPRO <sup>®</sup> CIPRO <sup>®</sup> Suspension CIPRO XR <sup>®</sup> FLOXIN <sup>®</sup> MAXAQUIN <sup>®</sup> NOROXIN <sup>®</sup>

### QUINOLONES - THIRD GENERATION

NO PA REQUIRED “PREFERRED”	PA REQUIRED
AVELOX <sup>®</sup> AVELOX ABC PACK <sup>®</sup>	LEVAQUIN <sup>®</sup> TEQUIN <sup>®</sup> ZAGAM <sup>®</sup>

## Antifungals (Oral) for Onychomycosis

**LENGTH OF AUTHORIZATIONS:** For the duration of the prescription (up to 6 months)

Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
  - Contraindication to or drug-to-drug interaction with medications not requiring prior approval.
  - History of unacceptable/toxic side effects to medications not requiring prior approval
- Document clinically compelling information

If the patient has a serious illness that causes them to be immunocompromised (i.e. AIDS, cancer, etc.) then may approve the requested medication.

### **ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION**

1. If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital or other similar location, or if the patient has just become Medicaid eligible and is already on a course of treatment with a medication requiring prior approval, then may approve the requested medication.
2. If the request is for a diagnosis other than fungal infection, please refer to a clinical pharmacist.

### **Sporanox**

If Sporanox is requested for any other FDA approved indication (other than onychomycosis), then approve for 6 months or the duration of the prescription.

Indications: Aspergillosis, Candidiasis (oral or esophageal), Histoplasmosis, Blastomycosis, empiric treatment of febrile neutropenia

Transfer requests for any other diagnosis to a clinical pharmacist.

### **ORAL ANTIFUNGALS USED FOR ONYCHOMYCOSIS**

NO PA REQUIRED "PREFERRED"	PA REQUIRED
LAMISIL®	ITRACONAZOLE SPORANOX®

## Antihistamines: Second Generation

### **LENGTH OF AUTHORIZATIONS:** 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
  - Allergy to medications not requiring prior approval
  - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
  - History of unacceptable/toxic side effects to medications not requiring prior approval
 Document clinically compelling information
2. If there has been a therapeutic failure after a course of treatment (e.g., one month for allergic rhinitis) with a preferred product (loratadine), then may approve the requested medication. Document details

### ANTI-HISTAMINES: SECOND GENERATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED <i>(medications in italics have a preferred generic available)</i>
ALAVERT <sup>®</sup> (compares to Claritin <sup>®</sup> Redi-tab and Claritin <sup>®</sup> tablets but is available OTC) LORATADINE D 12HR LORATADINE D 24HR LORATADINE Syrup (compares to Claritin <sup>®</sup> ) LORATADINE tablets (compares to Claritin <sup>®</sup> )	ALLEGRA <sup>®</sup> ALLEGRA D <sup>®</sup> CLARINEX <sup>®</sup> CLARINEX SYRUP <sup>®</sup> CLARINEX Redi-Tab <sup>®</sup> <i>CLARITIN<sup>®</sup></i> <i>CLARITIN D 12 HOUR<sup>®</sup></i> <i>CLARITIN D 24 HOUR<sup>®</sup></i> <i>CLARITIN REDI-TAB<sup>®</sup></i> <i>CLARITIN SYRUP<sup>®</sup></i> (no PA req. for children < 6 years) ZYRTEC <sup>®</sup> ZYRTEC D <sup>®</sup> ZYRTEC SYRUP <sup>®</sup> (no PA req. for children < 2 years)

## Antimigraine Medications: Serotonin Receptor Agonists “Triptans”

**LENGTH OF AUTHORIZATIONS:** 6 months

1. Is there any reason the patient cannot be switched to a non-prior approved medication?  
Acceptable reasons include:
  - Allergy to **one** of the non-prior approved products
  - Contraindication to all non-prior approved product(s)
  - History of unacceptable side effects to **one** of the non-prior approved product(s)Document clinically compelling information
2. Has the patient had therapeutic trial of **one** non-prior authorized drug that failed? If so, document and allow the prior authorized medication.

**CLINICAL CONSIDERATIONS:**

Prior Authorization will not be given for prophylactic therapy of migraine headache unless the patient has exhausted or has contraindications to all other “controller” migraine medications (i.e., beta-blockers, calcium channel blockers, etc) and the physician and patient are aware of the adverse risk potential.

NO PA REQUIRED “PREFERRED”	PA REQUIRED
IMITREX <sup>®</sup> (kit, nasal, tablets, vial) MAXALT <sup>®</sup> MAXALT-MLT <sup>®</sup>	AMERGE <sup>®</sup> AXERT <sup>®</sup> FROVA <sup>®</sup> RELPAX <sup>®</sup> ZOMIG <sup>®</sup> ZOMIG-ZMT <sup>®</sup>



## Beta-Adrenergic Agents

**LENGTH OF AUTHORIZATIONS:** 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class and formulation?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. If there has been a therapeutic failure to no less than a **two-week** trial of at least **one** medication not requiring prior approval **within the same class and formulation.** (ie nebulizers for nebulizers)

### **ADDITIONAL INFORMATION**

Patients experience cardiac and central nervous system side effects (i.e. tachycardia, agitation) more often.

See next page for specific drug lists.

## Beta-Adrenergic Agents *(page 2)*

**BETA-ADRENERGIC AGENTS****Short Acting and Combination Meter Dose Inhalers or Inhalation Devices**

<b>NO PA REQUIRED "PREFERRED"</b>	<b>PA REQUIRED</b> <i>(medications in italics have a preferred generic available)</i>
ALBUTEROL (compares to Proventil <sup>®</sup> , Ventolin <sup>®</sup> ) ALBUTEROL HFA ALUPENT <sup>®</sup> MDI (Metaproterenol) COMBIVENT <sup>®</sup> MDI (Ipratropium/Albuterol) MAXAIR AUTONHALER <sup>®</sup> (Pirbuterol) PROVENTIL <sup>®</sup> HFA (Albuterol) VENTOLIN <sup>®</sup> HFA (Albuterol)	<i>PROVENTIL<sup>®</sup></i> <i>VENTOLIN<sup>®</sup></i>

**BETA-ADRENERGIC AGENTS: LONG ACTING Meter Dose Inhalers**

<b>NO PA REQUIRED "PREFERRED"</b>	<b>PA REQUIRED</b>
FORADIL <sup>®</sup> (Formoterol) SEREVENT DISKUS <sup>®</sup> (Salmeterol)	

**BETA-ADRENERGIC AGENTS: SHORT-ACTING and COMBINATION Nebulizers**

<b>NO PA REQUIRED "PREFERRED"</b>	<b>PA REQUIRED</b> <i>(medications in italics have a preferred generic available)</i>
ACCUNEB <sup>®</sup> (Albuterol – pediatric dosing of premixed nebs) ALBUTEROL (compares to Proventil <sup>®</sup> , Ventolin <sup>®</sup> ) DUONEB <sup>®</sup> (Ipratropium/Albuterol) nebs METAPROTERNOL (compares to Alupent <sup>®</sup> for nebulization) XOPENEX <sup>®</sup> (Levalbuterol nebulization)	<i>PROVENTIL<sup>®</sup></i>

**Calcium Channel Blockers:**  
***Dihydropyridine Calcium Channel Blockers and***  
***Non-dihydropyridine Calcium Channel Blockers***

CLINICAL NOTES

There are two main classes of Calcium Channel Blockers (each with different actions on the peripheral vasculature and cardiac tissue):

1. Dihydropyridine Calcium Channel Blockers (DHPCCB)
2. Non-Dihydropyridine Calcium Channel Blockers (NDHPCCB)

Vascor is in its own third class of Calcium Channel Blockers and not included under PA requirements on the VA PDL at this time.

The requested medication may be approved if both of the following are true:

1. If there has been a therapeutic failure to no less than a **one-month** trial of at least **one** medication **within the same class** not requiring prior approval
2. The requested medications corresponding generic (if a generic is available and covered by the state) has been attempted and failed or is contraindicated

See next page for specific drug lists.

## Calcium Channel Blockers:

### *Dihydropyridine Calcium Channel Blockers and Non-dihydropyridine Calcium Channel Blockers (cont.)*

#### Dihydropyridine Calcium Channel Blockers (DHPCCB)

NO PA REQUIRED "PREFERRED"	PA REQUIRED <i>(medications in italics have a preferred generic available)</i>
AFEDITAB CR <sup>®</sup> DYNACIRC <sup>®</sup> DYNACIRC CR <sup>®</sup> FELODIPINE NICARDIPINE NIFEDIAC CC <sup>®</sup> NIFEDICAL XL <sup>®</sup> NIFEDIPINE ER NIFEDIPINE IMMEDIATE RELEASE NIFEDIPINE SA NORVASC <sup>®</sup> PLENDIL <sup>®</sup> SULAR <sup>®</sup>	<i>ADALAT CC<sup>®</sup></i> <i>CARDENE<sup>®</sup></i> CARDENE SR <sup>®</sup> <i>PROCARDIA<sup>®</sup></i> <i>PROCARDIA XL<sup>®</sup></i>

#### NON Dihydropyridine Calcium Channel Blockers (NDHPCCB)

NO PA REQUIRED "PREFERRED"	PA REQUIRED <i>(medications in italics have a preferred generic available)</i>
CARTIA XT <sup>®</sup> DILTIA XT <sup>®</sup> DILTIAZEM (compares to Cardizem <sup>®</sup> ) DILTIAZEM extended/sustained release TAZTIA XT <sup>®</sup> VERAPAMIL (compares to Calan <sup>®</sup> ) VERAPAMIL extended/sustained release	<i>CALAN<sup>®</sup></i> <i>CALAN SR<sup>®</sup></i> <i>CARDIZEM<sup>®</sup></i> <i>CARDIZEM CD<sup>®</sup></i> <i>CARDIZEM LA<sup>®</sup></i> <i>CARDIZEM SR<sup>®</sup></i> COVERA HS <sup>®</sup> <i>DILACOR XR<sup>®</sup></i> <i>ISOPTIN SR<sup>®</sup></i> <i>TIAZAC<sup>®</sup></i> <i>VERELAN<sup>®</sup></i> VERELAN PM <sup>®</sup>

## Central Nervous System Stimulants/ADHD Medications

**LENGTH OF AUTHORIZATION:** 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
  - Allergy to medications not requiring prior approval
  - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
  - History of unacceptable/toxic side effects to medications not requiring prior approvalDocument clinically compelling information
2. If there has been a therapeutic failure to no less than a **one-month trial** of at least **one** medication not requiring prior approval, then may approve the requested medication. Document details.
3. The patient must have failed the generic product (if covered by the State) before the brand is authorized.
4. If the patient requires a prior authorized medication based on a specific medical need that is not covered by the FDA indications of the preferred medications, then allow the non-preferred medication. This should be reviewed for need at each request for reauthorization.

## Central Nervous System Stimulants/ADHD Medications (page 2)

### DEXTROAMPHETAMINE and DEXTROAMPHETAMINE and AMPHETAMINE MIXTURES

NO PA REQUIRED "PREFERRED"	PA REQUIRED <i>(medications in italics have a preferred generic available)</i>
ADDERALL XR <sup>®</sup> AMPHETAMINE SALT COMBO DEXTROAMPHETAMINE DEXTROAMPHETAMINE SR DEXTROSTAT <sup>®</sup>	<i>ADDERALL<sup>®</sup></i> <i>DESOXYN<sup>®</sup></i> <i>DEXEDRINE<sup>®</sup></i> <i>DEXEDRINE SPANSULES<sup>®</sup></i> Methamphetamine HCL

### METHYLPHENIDATE PRODUCTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED <i>(medications in italics have a preferred generic available)</i>
CONCERTA <sup>®</sup> FOCALIN <sup>®</sup> METADATE CD <sup>®</sup> METADATE ER METHYLIN <sup>®</sup> METHYLIN ER <sup>®</sup> METHYLPHENIDATE METHYLPHENIDATE SR RITALIN LA <sup>®</sup>	<i>RITALIN<sup>®</sup></i> <i>RITALIN SR<sup>®</sup></i>

### MISCELLANEOUS

NO PA REQUIRED "PREFERRED"	PA REQUIRED <i>(medications in italics have a preferred generic available)</i>
PEMOLINE STRATTERA <sup>®</sup>	<i>CYLERT<sup>®</sup></i> PROVIGIL <sup>®</sup>

## COX-2 Inhibitors

**LENGTH OF AUTHORIZATIONS:** 1 year

The preferred product Celebrex<sup>®</sup> may be approved for patients if one of the following is true:

- If there has been a therapeutic trial and failure on a minimum of two (2) different non-COX2 NSAIDs
- Concurrent use of anticoagulants (warfarin or heparin)
- Chronic use of oral corticosteroids
- Concurrent use of methotrexate
- History of previous GI bleed or conditions associated with GI toxicity risk factors (i.e., PUD, GERD, etc.)
- If there is a specific indication for medication requiring prior approval, for which medications not requiring prior approval are not indicated, then document details and refer caller to a clinical pharmacist
- Patients with a diagnosis of familial adenomatous polyposis (FAP) presenting with a prescription for celecoxib (Celebrex<sup>®</sup>) may be approved without any risk factors or trials on NSAIDs.

### **CRITICAL INFORMATION TO CONSIDER**

1. If the patient is allergic to one NSAID or aspirin, the patient may be allergic to other NSAIDs.
2. If allergic to sulfonamides, a patient should not receive Celebrex<sup>®</sup>.

#### **ANALGESICS: COX-II's**

<b>NO PA REQUIRED</b>		<b>PA REQUIRED</b>	
CELEBREX <sup>®</sup>			

## Gastrointestinals: H2RAs

**LENGTH OF AUTHORIZATIONS:** 1 year

Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

Allergy to medications not requiring prior approval

Contraindication to or drug-to-drug interaction with medications not requiring prior approval

History of unacceptable/toxic side effects to medications not requiring prior approval

Patient's condition is clinically unstable; changing to a medication not requiring prior approval might cause deterioration of the patient's condition.

Document clinically compelling information

If there has been a therapeutic failure to no less than a **one-month trial** of at least **one** similar medication not requiring prior approval, then may approve the requested medication.

Document details

If a medication requiring prior approval was initiated in the hospital for the treatment of a condition such as a GI bleed, then may approve the requested medication.

**GASTROINTESTINALS: H2RAS**

NO PA REQUIRED "PREFERRED"	PA REQUIRED <i>(medications in italics have a preferred generic available)</i>
RANITIDINE (Generic for Zantac®)	AXID® CIMETIDINE (generic for Tagamet®) FAMOTIDINE (generic for Pepcid®) NIZATIDINE (generic for Axid®) PEPCID® PEPCID SUSPENSION® TAGAMET® ZANTAC® ZANTAC EFFERVESCENT® ZANTAC SYRUP® (No PA required if < 12 yrs)



## Gastrointestinals: Proton Pump Inhibitors

**LENGTH OF AUTHORIZATIONS:** 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:  
 Allergy to medications not requiring prior approval  
 Contraindication to or drug-to-drug interaction with medications not requiring prior approval  
 History of unacceptable/toxic side effects to medications not requiring prior approval  
 Patient's condition is clinically unstable; changing to a medication not requiring prior approval might cause deterioration of the patient's condition.  
 Document clinically compelling information
2. If there has been a therapeutic failure to no less than a **one-month trial** with Protonix, then may approve the requested medication.  
 Document details
3. If a medication requiring prior approval was initiated in the hospital for the treatment of a condition such as a GI bleed, then may approve the requested medication.

### GASTROINTESTINALS: PPIS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
PROTONIX® PRILOSEC® OTC	ACIPHEX® NEXIUM® OMEPRAZOLE (No PA required if < 12 yrs) PREVACID® (No PA required if < 12 yrs) PREVACID® Susp (No PA required if < 12 yrs) PREVACID SoluTab® PRILOSEC® (Rx)

**SPECIAL CONSIDERATION:**

Protonix® is a delayed release tablet and cannot be crushed or opened. For tubed patients or patients with swallowing difficulties omeprazole, Prevacid®, Prevacid Solutab®, Prilosec®, Nexium or Prevacid® granules (if oral administration) can be used. These Proton Pump Inhibitors may be opened and the intact granules may be mixed in apple sauce or orange juice and administered. Alternatively, the capsules may be opened and the granules may be dissolved in a small amount of sodium bicarbonate to form a compounded suspension for administration. The omeprazole will be the preferred agent for these circumstances and may be approved. If there has been a therapeutic failure on omeprazole or there is a clinical contraindication to omeprazole then another non-preferred agent may be approved.

Aciphex® is an extended release tablet and should not be opened or crushed .

## Glaucoma Agents

**LENGTH OF AUTHORIZATIONS:**      1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?  
Acceptable reasons include:
  - Allergy to medications not requiring prior approval
  - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
  - History of unacceptable/toxic side effects to medications not requiring prior approvalDocument clinically compelling information
2. The requested medication may be approved if both of the following are true:  
If there has been a therapeutic failure to no less than a **one-month trial** of at least **one** medication **within the same class** not requiring prior approval
3. The requested medications corresponding generic (if a generic is available) has been attempted and failed or is contraindicated

## Glaucoma Agents *(page 2)*

### ALPHA 2 ADRENERGIC AGENTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED <i>(medications in italics have a preferred generic available)</i>
ALPHAGAN P <sup>®</sup> BRIMONIDINE TARTRATE IOPIDINE <sup>®</sup>	<i>ALPHAGAN<sup>®</sup></i>

### BETA BLOCKERS

NO PA REQUIRED "PREFERRED"	PA REQUIRED <i>(medications in italics have a preferred generic available)</i>
BETAXOLOL HCL BETIMOL <sup>®</sup> BETOPTIC S <sup>®</sup> CARTEOLOL HCL LEVOBUNOLOL HCL METIPRANOLOL TIMOLOL MALEATE TIMOLOL MALEATE gel-forming	<i>BETAGAN<sup>®</sup></i> <i>ISTALOL<sup>®</sup></i> <i>OCUPRESS<sup>®</sup></i> <i>OPTIPRANOLOL<sup>®</sup></i> <i>TIMOPTIC<sup>®</sup></i> <i>TIMOPTIC XE<sup>®</sup></i>

### CARBONIC ANHYDRASE INHIBITOR (CAI)

NO PA REQUIRED "PREFERRED"	PA REQUIRED
AZOPT <sup>®</sup> COSOPT <sup>®</sup> TRUSOPT <sup>®</sup>	

### PROSTAGLANDIN ANALOGS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
LUMIGAN <sup>®</sup> TRAVATAN <sup>®</sup> XALATAN <sup>®</sup>	RESCULA <sup>®</sup>

## **Glucocorticoids: Inhaled and Nasal Steroids**

**LENGTH OF AUTHORIZATIONS:**      1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?  
Acceptable reasons include:
  - Allergy to medications not requiring prior approval
  - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
  - History of unacceptable/toxic side effects to medications not requiring prior approval
  - Patient's condition is clinically unstable—patient has had an ER visit or at least two hospitalizations for asthma in the past thirty days—changing to a medication not requiring prior approval might cause deterioration of the patient's condition.Document clinically compelling information
2. If there have been therapeutic failures to no less than **one-month** trials of at least **two** medications not requiring prior approval, then may approve the requested medication.  
Document details

**ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION**

1. If a medication requiring prior approval was initiated in the hospital, then may approve the requested medication.  
Document details
2. If the patient is a child <13 years old or a patient with a significant disability, and unable to use an inhaler which does not require prior approval, or is non-compliant on an inhaler not requiring prior approval because of taste, dry mouth, infection; then may approve the requested medication.  
Document details

See next page for specific drug lists.

## Glucocorticoids: Inhaled Steroids

### GLUCOCORTICOIDS: INHALED

#### GLUCOCORTICOIDS: Meter Dose Inhalers Only

NO PA REQUIRED "PREFERRED"	PA REQUIRED
AEROBID <sup>®</sup> AEROBID M <sup>®</sup> AZMACORT <sup>®</sup> FLOVENT <sup>®</sup> FLOVENT HFA <sup>®</sup> QVAR <sup>®</sup>	FLOVENT ROTADISK <sup>®</sup> PULMICORT TURBUHALER <sup>®</sup>

#### GLUCOCORTICOIDS and LONG-ACTING BETA<sub>2</sub> ADRENERGIC AGENTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ADVAIR DISKUS <sup>®</sup> (Salmeterol/Fluticasone)	

#### GLUCOCORTICOIDS: Nebulized

NO PA REQUIRED "PREFERRED"	PA REQUIRED
PULMICORT <sup>®</sup> RESPULES NEBULIZER SOLUTION	

## Glucocorticoids: Intranasal Steroids

### GLUCOCORTICOIDS: INTRANASAL STEROIDS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
FLONASE <sup>®</sup> FLUNISOLIDE NASALIDE <sup>®</sup> NASAREL <sup>®</sup>	BECONASE AQ <sup>®</sup> NASACORT <sup>®</sup> NASACORT AQ <sup>®</sup> NASONEX <sup>®</sup> (no PA required if < 4 years) RHINOCORT AQUA <sup>®</sup> TRI-NASAL <sup>®</sup>

## Leukotriene Receptor Antagonists

**LENGTH OF AUTHORIZATIONS:** 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. If there has been a therapeutic failure to the agent not requiring prior approval, then may approve the requested medication.

Document details

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ACCOLATE® SINGULAIR®	

## Lipotropics

**LENGTH OF AUTHORIZATIONS:** 1 year

<b>Trial period</b>	1 month (30 days) for HMG COA Reductase Inhibitors,
<b>Number of non-PA agents (generic)</b>	1 medication – The assumption is that the medication must be in the same class of the medication requested
<b>Length of Authorization</b>	1 year

General Guidelines:

Currently there are three classes of medications in the Lipotropics represented. Each class has a different mechanism of action and acts on different components of total cholesterol

Fibric acid derivatives (*not included in VA PDL at this time*)

HMG COA reductase Inhibitors

Nicotinic acid derivatives (*not included in VA PDL at this time*)

Bile Acid Resins (*not included in VA PDL at this time*)

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Patient's condition is clinically unstable; changing to a medication not requiring prior approval might cause deterioration of the patient's condition.

Document clinically compelling information

2. If there have been therapeutic failures to no less than **one-month** trials of at least **one** medication not requiring prior approval, then may approve the requested medication.

Document details

### HMG-COA Reductase Inhibitors "Statins"

NO PA REQUIRED "PREFERRED"	PA REQUIRED <i>(medications in italics have a preferred generic available)</i>
ADVICOR® ALTOCOR® LESCOL® LESCOL XL® LOVASTATIN (compares to Mevacor®) PRAVACHOL® ZOCOR®	CADUET® (Norvasc® and Lipitor®) CRESTOR® LIPITOR® <i>MEVACOR®</i>

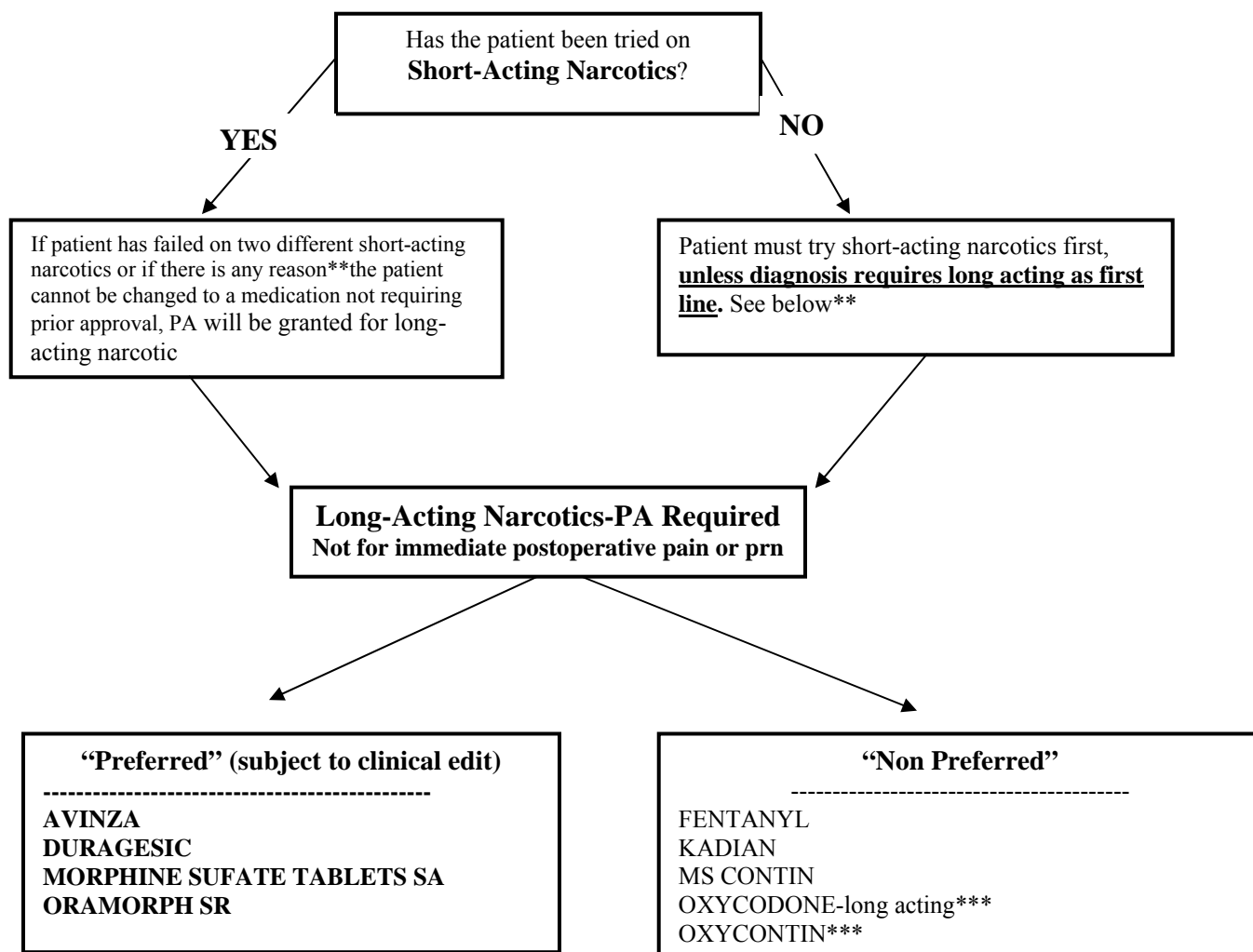
## Long Acting Narcotics – Step Therapy

### SHORT ACTING NARCOTICS (no PA required)

Butalbital Combinations	Methadone*
Butalbital w/codeine	Morphine-short acting
Codeine	Nalbuphine
Codeine w/APAP	Oxycodone-short acting
Codeine w/ASA	Oxycodone w/APAP
Hydrocodone	Oxycodone w/ASA
Hydrocodone w/APAP	Oxymorphone
Hydromorphone	Pentazocine combinations
Levorphanol	Propoxyphene combinations
Meperidine	

*\*The use of methadone for pain should ideally be done in the context of an organized pain clinic, hospice or with assistance of local pain management experts, including health care providers or pharmacists, who have experience with methadone use.*

### Step-Therapy





**\*\*Step-Therapy is not required for those patients that have been stabilized on Long Acting Narcotics or need relief of moderate to severe pain requiring around-the-clock opioid therapy, for an extended period of time. Additional acceptable reasons include:**

- Allergy to medications not requiring prior approvals
- Contraindications to or drug-to-drug interaction with medications not requiring prior approval
- *If the patient has a diagnosis that is an approved indication for the medication that requires prior approval and this diagnosis is not an indication for the medications that do not require prior approval.*
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

**LENGTH OF AUTHORIZATIONS:** 1- year

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**OxyContin\*\*\* / Oxycodone-long acting\*\*\*Guidelines**

1. Coverage is limited to those persons 18 years of age or older with a need for a continuous around-the-clock analgesic for an extended period of time for the management of moderate to severe pain.

2. There are no diagnosis restrictions here. The main objective is to verify appropriate use and the following items should be taken into consideration when reviewing an oxycontin request:

- Dosing frequency greater than bid (tid for an identified, organized pain clinic or pain specialist)
- Dosing using multiple small strength tablets as opposed to a single higher strength tablets
- Odd quantities that would result in fractional dosing
- Patient history of substance abuse
- Frequent early refill attempts
- Multiple request pertaining to lost medication
- Short-term or prn use (oxycontin is not indicated for short-term or prn use)
- Any suspicious use reported by pharmacies or physicians
- A rapid increase in dosage
- 80mg tablets are for opioid tolerant patients only

3. Reasons for denial:

- Split tablets
- Greater than tid dosing frequency
- Concurrent use of other extended release opioids
- Prn dosing

1997 medical society of Virginia and house of delegates guidelines Virginia code 54.1-2971.01 states:

**"In the case of a patient with intractable pain, the attending physician may prescribe a dosage in excess of the recommended dosage of a pain relieving agent if he certifies the medical necessity for such excess dosage in the patient's medical record. Any person who prescribes, dispenses or administers an excess dosage in accordance with this section shall not be deemed to be in violation of the provisions of this title because of such excess dosage, if such excess dosage is prescribed, dispensed or administered in good faith for accepted medicinal or therapeutic purposes. Nothing in this section shall be construed to grant any person immunity from investigation or disciplinary action based on the prescription, dispensing or administration of an excess dosage in violation of this section."**

## NSAIDs (Non-Steroidal Anti-inflammatory Drugs)

**LENGTH OF AUTHORIZATIONS:** 1 YEAR

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. The requested medication may be approved if **both** of the following are true:
  - If there has been a therapeutic failure to no less than a **one-month** trial of at least **two** medication(s) within the same class not requiring prior approval
  - The requested medications corresponding generic (if a generic is available) has been attempted and failed or is contraindicated.
3. If there is a specific indication for a medication requiring prior approval, for which medications not requiring prior approval are not indicated, then document details and refer to a clinical pharmacist.

### **ADDITIONAL INFORMATION TO CONSIDER**

If the patient is allergic to one NSAID or aspirin, the patient may be allergic to other NSAIDs.

## NSAIDs (Non-Steroidal Anti-inflammatory Drugs)

(page 2)

NO PA REQUIRED “PREFERRED”	PA REQUIRED <i>(medications in italics have a preferred generic available)</i>
<p>DICLOFENAC POTASSIUM (Generic for Cataflam<sup>®</sup>)            DICLOFENAC SODIUM (Generic for Voltaren<sup>®</sup>)            DIFLUNISAL (Generic for Dolobid<sup>®</sup>)            ETODOLAC (Generic for Lodine<sup>®</sup> and Lodine XL<sup>®</sup>)            FENOPROFEN (Generic for Nalfon<sup>®</sup>)            FLURBIPROFEN (Generic for Ansaid<sup>®</sup>)            IBUPROFEN (Generic for Motrin<sup>®</sup>)            INDOMETHACIN (Generic for Indocin<sup>®</sup>)            INDOMETHACIN SR (Generic for Indocin SR<sup>®</sup>)            KETOPROFEN (Generic for Orudis<sup>®</sup>)            KETOPROFEN ER (Generic for Oruvail<sup>®</sup>)            KETOROLAC (Generic for Toradol<sup>®</sup>)            MECLOFENAMATE SODIUM (Generic for Meclomen<sup>®</sup>)            NABUMETONE (Generic for Relafen<sup>®</sup>)            NAPROXEN (Generic for Naprosyn<sup>®</sup>)            NAPROXEN SODIUM (Generic for Anaprox<sup>®</sup>)            OXAPROZIN (Generic for Daypro<sup>®</sup>)            PIROXICAM (Generic for Feldene<sup>®</sup>)            SULINDAC (Generic for Clinoril<sup>®</sup>)            TOLMETIN SODIUM (Generic for Tolectin<sup>®</sup> and Tolectin DS<sup>®</sup>)</p>	<p><i>ANAPROX<sup>®</sup></i>  <i>ANAPROX DS<sup>®</sup></i>  <i>ANSIAD<sup>®</sup></i>            ARTHROTEC 50<sup>®</sup>            ARTHROTEC 75<sup>®</sup>  <i>CATAFLAM<sup>®</sup></i>  <i>CLINORIL<sup>®</sup></i>  <i>DAYPRO<sup>®</sup></i>  <i>DOLOBID<sup>®</sup></i>  <i>FELDENE<sup>®</sup></i>  <i>INDOCIN<sup>®</sup></i>  <i>LODINE<sup>®</sup></i>  <i>LODINE XL<sup>®</sup></i>            MOBIC<sup>®</sup>  <i>MOTRIN<sup>®</sup></i>  <i>NALFON<sup>®</sup></i>  <i>NAPRELAN<sup>®</sup></i>            PREVACID NAPRAPAC<sup>®</sup> <i>(must also meet PPI criteria – see page 17)</i>  <i>NAPROSYN<sup>®</sup></i>  <i>ORUDIS<sup>®</sup></i>  <i>ORUVAIL<sup>®</sup></i>            PONSTEL<sup>®</sup>  <i>RELAFEN<sup>®</sup></i>  <i>TOLECTIN DS<sup>®</sup></i>  <i>TORADOL<sup>®</sup></i>  <i>VOLTAREN<sup>®</sup></i>  <i>VOLTAREN-XR<sup>®</sup></i></p>

## Oral Hypoglycemics

### LENGTH OF AUTHORIZATIONS: 1 YEAR

1. Is there any reason the patient cannot be switched to a non-prior approved medication?

Acceptable reasons include:

- Allergy to the non-prior approved products in this class
- Contraindication or drug to drug interaction with all non-prior approved products
- History of unacceptable side effects

Document clinically compelling information

2. Has the patient tried and failed a therapeutic trial of thirty days with **one** of the non-preferred drugs **within the same class**? If so, document and approve the prior authorized drugs.

### ALPHA-GLUCOSIDASE INHIBITORS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
GLYSET <sup>®</sup> (Miglitol) PRECOSE <sup>®</sup> (Acarbose)	

### BIGUANIDES

NO PA REQUIRED "PREFERRED"	PA REQUIRED <i>(medications in italics have a preferred generic available)</i>
METFORMIN (compares to Glucophage <sup>®</sup> ) METFORMIN ER (compares to Glucophage XR <sup>®</sup> )	<i>GLUCOPHAGE<sup>®</sup></i> <i>GLUCOPHAGE XR<sup>®</sup></i> RIOMET <sup>®</sup> (metformin suspension)

### BIGUANIDES COMBINATION PRODUCTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
AVANDAMET <sup>®</sup> (Metformin/Avandia) GLYBURIDE-METFORMIN HCL GLUCOVANCE <sup>®</sup> (Metformin/Glyburide) METAGLIP <sup>®</sup> (Metformin/Glipizide)	

### MEGLITINIDES

NO PA REQUIRED "PREFERRED"	PA REQUIRED
STARLIX <sup>®</sup>	PRANDIN <sup>®</sup>

### THIAZOLIDINEDIONES

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ACTOS <sup>®</sup> AVANDIA <sup>®</sup>	

## Oral Hypoglycemics page 2

### SULFONYLUREAS SECOND GENERATION

NO PA REQUIRED "PREFERRED"	<b><i>PA REQUIRED</i></b> <i>(medications in italics have a preferred generic available)</i>
GLIPIZIDE (compares to Glucotrol®) GLIPIZIDE ER (compares to Glucotrol XL®) GLYBURIDE (compares to Diabeta®) GLYBURIDE MICRONIZED (compares to Glynase®)	AMARYL® <i>DIABETA®</i> <i>GLUCOTROL®</i> <i>GLUCOTROL XL®</i> <i>GLYNASE®</i> <i>MICRONASE®</i>

## Osteoporosis Agents - Bisphosphonates

**LENGTH OF AUTHORIZATIONS:** 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to medication not requiring prior approval
- Contraindication to or drug-to-drug interaction with medication not requiring prior approval
- History of unacceptable/toxic side effects to medication not requiring prior approval

Document clinically compelling information

2. Has the patient tried and failed a therapeutic trial with a non-preferred drug **within the same class**? If so, document and approve the prior authorized drug.

### Bisphosphonates

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ACTONEL® FOSAMAX® FOSAMAX Plus D® FOSAMAX Solution®	BONIVA®

## Sedative/Hypnotics (Non-Barbiturate)

**LENGTH OF AUTHORIZATIONS:** Length of the prescription (up to 3 months)

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
  - Allergy to medications not requiring prior approval
  - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
  - History of unacceptable/toxic side effects to medications not requiring prior approval
  - Document clinically compelling information
2. If there has been a therapeutic failure to no less than a **one-month** trial of at least **one** medication not requiring prior approval, then may approve the requested medication. Document details
3. If the request is for Ambien® for a **pregnant** patient, approve the Ambien® for the duration of the prescription or the duration of the pregnancy (whichever is shorter).
4. For **patients age 65 and older**, Ambien may be approved after a trial of trazodone (duration = at least one month). It is not necessary for patient's  $\geq 65$  to try a benzodiazepine if they have had a trial of trazodone.

### SEDATIVE / HYPNOTICS (NON-BARBITURATE)

NO PA REQUIRED "PREFERRED"	PA REQUIRED <i>(medications in italics have a preferred generic available)</i>
ESTAZOLAM (compares to Prosom®) FLURAZEPAM (compares to Dalmane®) RESTORIL® 7.5 mg (until generic available) TEMAZEPAM (compares to Restoril®) TRIAZOLAM (compares to Halcion®)	AMBIEN® <i>DALMANE®</i> DORAL® <i>HALCION®</i> <i>LUNESTA®</i> <i>PROSOM®</i> <i>RESTORIL®</i> SOMNOTE® SONATA®